



Testimony
Before the Subcommittee on Oversight and
Investigations
Committee on Energy and Commerce
United States House of Representatives

**“Hospital Disaster Preparedness: Past,
Present, and Future”**

Statement of

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Mr. Chairman and Members of the Subcommittee, I am pleased to be here today to discuss the Department of Health and Human Services (HHS) emergency preparedness strategies. The past few months have been a challenging time for HHS and our nation as a whole.

On August 29, 2005, Hurricane Katrina struck the Gulf Coast just east of New Orleans, near Gulfport, MS. The storm's impact was significantly increased by the failure of the Lake Pontchartrain levee around New Orleans on August 30th. On September 23, 2005 Hurricane Rita made landfall east of Port Arthur, Texas. The storms forced the evacuation of over 4 million people, destroyed tens of thousands of businesses, and over 100,000 homes, forced the long-term relocation of over 685,000 families, destroyed at least 8 hospitals, and were responsible for the deaths of over 1,200 people. By comparison, the four Florida hurricanes of 2004 required the long-term relocation of 20,000 people, and at the time, set a record for that statistic.

HHS Response to Hurricane Disasters

HHS Secretary Mike Leavitt declared public health emergencies in the affected areas and announced he was making available the Department's full complement of emergency response assets and resources to states, municipalities, hospitals and others in need of public health assistance for response to Hurricane Katrina. The HHS Operations Center, which operates 24 hours a day, increased its staff and was in constant communication with state

and local emergency management operations, as well as other federal departments.

Several of the Agencies within the Department have responsibility for hurricane and disaster preparedness efforts. To respond to this unprecedented natural disaster in our nation's history, the Health Resources and Services Administration (HRSA), US Public Health Service Commissioned Corps, and the Centers for Medicare & Medicaid Services (CMS) undertook extensive efforts, which I will discuss below.

Health Resources and Services Administration Response

During the hurricanes of 2005, several states were able to directly and indirectly aid in the recovery and restoration of health and medical care to the most severely impacted Gulf States. As a result of funds awarded through the HRSA National Bioterrorism Hospital Preparedness Program, North Carolina and Nevada provided on-site mobile medical facilities and associated medical teams, supplies and equipment to support these facilities. Other states that received large numbers of evacuees, many with pre-existing health conditions that had gone untreated for many days and weeks, were able to exercise surge plans, assemble and credential extra medical personnel and have adequate supplies of medications and equipment ready to receive and treat evacuees. Other states were able to donate communications equipment to the most severely impacted states to begin re-establishing communications with healthcare partners.

In the case of Katrina, HRSA's Emergency Systems for Advance Registration of Volunteer Health Professionals (ESAR-VHP) program began working shortly after the hurricane made landfall. The ESAR-VHP program worked with 21 states to provide "as-needed" assistance in the registration, credential verification, and deployment of volunteer medical and healthcare professionals to the Gulf region. Based on preliminary figures, these 21 states reported sending over 8,300 pre-credentialed volunteer medical and healthcare providers to assist in the Katrina response. To accomplish this, the ESAR-VHP program developed a temporary on-line registration and credential verification system that was used by seven states that had not yet started developing their ESAR-VHP systems. Secondly, the program successfully negotiated with major physician and nurse credentialing organizations for free verification of volunteer credentials for the duration of the emergency. Finally, the program assisted States in working with their State emergency management agency to deploy health and medical personnel through the Emergency Management Assistance Compact in compliance with the National Response Plan.

US Public Health Service Commissioned Corps Response

Per requests from Louisiana, the HHS Office of the Surgeon General provided extensive support through the Commissioned Corps (CC):

- Supported a Secretary's Emergency Response Team (SERT) in Baton Rouge, with responsibility for all Emergency Support Function #8 incident

leadership, command, operations, and logistics.

- Provided assistance for environmental health support for water, wastewater, sewer system, and food safety issues at schools, childcare centers, shelters, nursing homes, restaurants, pharmacies, and other retail establishments.
- Supported FEMA and the Strategic National Stockpile by coordinating the distribution of pharmaceutical caches to response teams.
- Staffed Special Needs Shelters across Louisiana to care for people who had been displaced from nursing homes, assisted living centers and private homes during both Katrina and Rita. These people were almost exclusively elderly, most had ambulation problems, many were on oxygen, and quite a few required electronic device support to sustain life.
- Staffed 3,550 beds in Federal Medical Shelters that were established to receive special needs patients and lower acuity hospital patients in Louisiana.
- Supported two animal rescue shelters in Louisiana.
- Worked with Disaster Mortuary Operations Response Teams and Family Assistance Centers in Louisiana to collect and identify the deceased and trying to match grieving families with loved ones.
- Visited shelters throughout Louisiana to provide tetanus, influenza, and other common vaccines.
- Staffed the Surgeon General's Call Center which recruited 34,000 + civilian volunteers 0willing to deploy as non-paid HHS employees. As a

result, more than 800 civilians were federalized and served in Louisiana.

- Formed public health teams to assess the health status of the population as well as the medical capacity of the impacted states.
- Provided mental health services in cooperation with the State Department of Education, to reach 200,000 school children that were dealing with the behavioral health issues related to the storms.
- Evaluated a large number of hazardous waste, petroleum spills, and chemical sites in the impacted states.

During this multi-state, multi-event response by over 2,500 Commissioned Corps officers, and 1,400 non-paid HHS civilians, they distinguished themselves in hundreds of ways with their exceptional work to support the citizens of Mississippi, Louisiana, Texas, and Florida. The dedicated service of Corps officers in this deployment truly made an impact on the health status of the stricken people of the Gulf States.

Centers for Medicare & Medicaid Services Hurricane Disaster Efforts

The Centers for Medicare & Medicaid Services (CMS) has acted to assure that the Medicare, Medicaid, State Children's Health Insurance Programs, and the Clinical Laboratory Improvement Amendments of 1988 (CLIA) have accommodated the emergency health care needs of beneficiaries and medical providers in states directly affected by Hurricane Katrina this year.

As part of the HHS effort to quickly aid beneficiaries and providers, Secretary Leavitt invoked time-limited statutory authority under section 1135(b) of the Social Security Act to permit CMS (and its agents) to waive or modify certain requirements, or modify certain deadlines and timetables for the performance of required activities, to ensure that sufficient health care items and services are available. The 1135 waivers have and will continue to assist states directly affected by Hurricane Katrina and states hosting evacuees. Furthermore, the Secretary authorized several section 1115 demonstrations, under which states may apply on a demonstration basis. These demonstrations help States to provide coverage to evacuees from the affected geographic areas of Louisiana, Mississippi, and Alabama, in which a Natural Disaster, consistent with the Stafford Act, has been declared.

In addition, CMS temporarily relaxed and waived many of the policy and billing requirements for hospitals and other providers to accommodate the emergency health care needs of beneficiaries and medical providers in the Hurricane Katrina affected states.

Residents of the states affected by the hurricane, and the providers in all states that are assisting victims have faced extraordinary circumstances and CMS fully supports the efforts of all providers to offer assistance. Further, state agencies and their staff were an important and crucial part of the preparation and response and continue to be an intrinsic part of the recovery phases. Hurricane Katrina

demonstrated the importance of our partnership with state agencies as contacts for communications, advocates/links for resources, and facilitators for the provision of health care for all of those in need of care.

In partnership with states, CMS has acted to speed the provision of health care services to the elderly, children, and persons with disabilities by relaxing normal operating procedures until providers can reasonably be expected to continue under the normal requirements. The Agency has been working closely with state Medicaid agencies to coordinate resolution of interstate payment agreements for recipients who are served outside their home states.

CMS moved quickly to support efforts of the health care community. The Agency made short-term administrative adjustments to our Medicare and Medicaid payment rules. CMS implemented a new Medicaid template waiver that provides for immediate, temporary Medicaid coverage and financial support for medical services that fall outside of standard Medicaid benefits, all using existing systems in affected states to put them into service quickly and effectively. In addition, CMS quickly established multiple strategies to communicate with affected providers about the changes. For instance, CMS posted question and answer documents on the CMS website; held special “Open Door Forums;” and arranged meetings with the affected states, national and state provider associations, and individual providers.

CMS Requirements for Emergency Situations

CMS works with a number of different entities, including state government agencies, professional associations, and contractors to ensure that entities receiving Medicare and Medicaid payments comply with established requirements for their provider type. These requirements are referred to as Conditions of Participation (CoPs) and Conditions for Coverage (CfCs). Besides requiring that providers have policies and procedures in place to ensure quality of patient care, these conditions also require that providers are adequately prepared to continue treating patients if an emergency situation occurs.

These conditions, which may reference other consensus standards such as the National Fire Protection Association codes, require organizations to have emergency contingency plans in place, for which requirements vary by provider type. CMS uses state health agencies and accrediting organizations to determine whether health care providers and suppliers meet Federal standards. CMS also ensures that the standards of accrediting organizations recognized by CMS (through a process called “deeming”) meet or exceed Medicare standards.

Regulations and guidance for hospitals

Hospitals are required to comply with CMS conditions of participation. As such, the hospitals must develop and implement a comprehensive plan to ensure that the safety and well-being of patients are assured during emergency situations.

The hospital must coordinate with Federal, State, and local emergency preparedness and health authorities to identify likely risks for their area (e.g., natural disasters; bioterrorism threats; disruption of utilities such as water, sewer, electrical communications, and fuel; nuclear accidents; industrial accidents; and other potential mass casualties) and to develop appropriate responses that will assure the safety and well-being of patients. Further, there must be emergency power and lighting in at least the operating, recovery, intensive care, and emergency rooms, and stairwells. In all other areas not serviced by the emergency supply source, battery lamps and flashlights must be available. Also, there must be facilities for emergency gas and water supply; however, there is no duration specified for the fuel supply.

In an emergency, CMS defers to State and local governments to consider issues such as the special needs of patient populations treated at the hospital (e.g., patients with psychiatric diagnosis, patients on special diets, or newborns); pharmaceuticals, food, other supplies and equipment that may be needed during emergency/disaster situations; communication to external entities if telephones and computers are not operating or become overloaded (e.g., use of satellite (cell) phones to reach community officials or other healthcare facilities if transfer of patients is necessary); and transfer or discharge of patients to home, other health care settings, shelters, or other hospitals.

CMS Conducts Oversight of Hospital Compliance

In addition to the regulations outlining the emergency preparedness requirements for all Medicare and Medicaid providers, CMS has multiple oversight functions in place to ensure that facilities adhere to the Agency's standards of operation.

CMS maintains oversight for compliance with the Medicare health and safety standards for hospitals serving Medicare and Medicaid beneficiaries, and makes available to beneficiaries, providers/suppliers, researchers and State surveyors information about these activities.

The survey (inspection) for this determination is done on behalf of CMS by the individual State Survey Agencies.

CMS Accommodated Emergency Health Care Needs After Hurricane Katrina

CMS has acted to assure that the Medicare, Medicaid and State Children's Health Insurance Programs were flexible to accommodate the emergency health care needs of beneficiaries and medical providers in the Hurricane Katrina devastated states. More specifically, many of the Medicare fee-for-service program's normal operating procedures were temporarily relaxed to speed provision of health care services to the elderly, children and persons with disabilities who depend upon them.

CMS Worked to Expand Availability of Inpatient Beds

To expand the availability of inpatient beds and ensure that patients have access to needed inpatient care, CMS waived many of Medicare's classification requirements, allowing specialized facilities and hospital units to treat patients needing inpatient care. For example,

- CMS did not count any bed use that exceeds the 25-bed or 96-hour average length of stay limits for critical access hospitals (CAHs) located in the public health emergency states if such use was related to the hurricane.
- CMS did not count admissions to inpatient rehabilitation facilities (IRFs) located in the public health emergency states toward compliance with the 75 percent rule if such admissions were related to the hurricane.
- CMS did not count patients admitted to a long-term care hospital (LTCH) located in the public health emergency states toward the calculation of the facility's average length of stay if such admissions were related to the hurricane.
- CMS allowed beds in a distinct psychiatric unit in an acute care hospital located in the public health emergency states to be available for patients needing inpatient acute care services if such use was related to the hurricane.

CMS Relaxed Medicare Billing Requirements and Accelerated Payments

To accommodate the emergency health care needs of beneficiaries, CMS temporarily relaxed Medicare billing requirements and offered accelerated payment options for providers furnishing such care. For example,

- CMS allowed hospitals to have a responsible physician at the hospital (e.g., chief of medical staff or department head) to sign an attestation when the attending physician could not be located.
- CMS allowed providers affected by the hurricane to file paper claims if necessary.
- CMS instructed its contractors to facilitate the processing of claims for services furnished by physicians to treat patients outside the normal settings (e.g., shelters).
- CMS paid the inpatient acute care rate and any cost outliers for Medicare patients that no longer needed acute level care but remained in a hospital located in the public health emergency states until the patient could be moved to an appropriate facility.
- For those teaching hospitals that were training residents that were displaced by the hurricane, CMS temporarily adjusted the hospital's full-time equivalent cap on residents, as needed, to allow the hospital to receive indirect or direct graduate medical education payments for those displaced residents. The temporary adjustment applied as long as the original program in which the displaced resident trained remained closed.
- Accelerated or advance payments were available to those providers who were still rendering some services or were taking steps to be able to furnish

services again, despite having their practice or business affected or destroyed by the hurricane.

- CMS instructed its contractors to process immediately any requests for accelerated payments or increases in periodic interim payments for providers affected by the hurricane.
- The intermediaries also were instructed to increase the rate of the accelerated payment to 100 percent and extend the repayment period to 180 days on a case-by-case basis.
- CMS instructed its intermediaries to approve requests for extensions to cost report filing deadlines for providers affected by the hurricane.
- The intermediaries also were instructed to accept other data they determined are adequate to substantiate payment to the provider when a facility's records were destroyed. This determination was done on a case-by-case basis.
- CMS allowed providers who waived the coinsurance and deductible amounts for indigent patients affected by the hurricane to claim bad debt, even in cases where documentation regarding a patient's indigence was unavailable. Providers were required to note their observations or submit any documentation they could along with a brief signed statement by medical personnel regarding the patient's indigence.

CMS Assistance Available for Rebuilding Health Care Infrastructure

CMS - Medicare Extraordinary Circumstances Exception Provision

The Medicare inpatient prospective payment system includes payment for hospital inpatient capital costs, which is made on a per-discharge basis. The extraordinary circumstances exception provision provides an additional payment if a hospital incurs unanticipated capital expenditures in excess of \$5 million (net of proceeds from other funding sources, including insurance, litigation, and government funding such as FEMA aid) due to extraordinary circumstances beyond the hospital's control (e.g., a flood, fire, or earthquake).

For most hospitals, the exception payments for extraordinary circumstances are based on 85 percent of Medicare's share of allowable capital costs (100 percent for sole-community hospitals) attributed to the extraordinary circumstance. The payments are made for the annualized portion of the extraordinary circumstance costs, over the useful lifetime of the assets, not in a lump sum. A hospital must make an initial written request to its CMS Regional Office (RO) within 180 days after the occurrence of the extraordinary circumstance causing the unanticipated expenditures.

CMS Makes Available Waiver of the Physician Self-Referral Law for Limited Cases

In response to the recent hurricane, CMS has received inquiries concerning whether hospitals can provide free office space, or low interest or no interest loans, or offer certain arrangements to physicians who have been displaced by

the hurricane. The Secretary has given CMS authority to waive sanctions for violations of the physician self-referral (Stark) law (which prohibits physicians from referring Medicare patients to an entity with which the physician or a member of the physician's immediate family has a financial relationship, unless the arrangement meets the criteria of one of the statutory or regulatory exceptions). The States in which the Stark waiver is available are limited to those States that have received a Section 1135 waiver due to Hurricane Katrina.

CMS is considering Stark waiver requests on a case-by-case basis and/or through guidance posted on the CMS website, and is waiving Stark violations in such circumstances as CMS determines appropriate. The focus is to ensure access to care and to assist displaced physicians in the affected areas. CMS is temporarily allowing arrangements that otherwise would not meet the specific criteria for an exception, provided that such arrangements do not lead to program or patient abuse, and that other safeguards which may be applicable to the specific arrangement under consideration exist.

The Role of Section 1115 Demonstrations

In an effort to ensure the continuity of health care services for the victims of Hurricane Katrina, CMS developed a new section 1115 demonstration initiative. Under this program, States were able to apply to be part of a unique cooperative demonstration that allows Medicaid and State Children's Health Insurance coverage of evacuees from the affected geographic areas of Louisiana,

Mississippi, and Alabama. Under this demonstration, effective retroactively to August 24, 2005, evacuees who were displaced from their homes as a result of Hurricane Katrina were provided the opportunity to enroll to receive services under the Medicaid or SCHIP programs in whatever State they now reside so long as the host state applied for a Katrina demonstration. The host states are allowed to provide their state's Medicaid/SCHIP benefit package and comprehensive State Plan services to evacuees, who can receive this coverage for up to 5 months. Evacuees apply through a simplified application within the Host State through January 31, 2006. This demonstration allows for self-attestation for items such as displacement, income, residency, resources, and immigration status if the evacuee is unable to provide documentation. There is no obligation on the Host State to redetermine eligibility for evacuees at the end of this period. States are encouraged to assist individuals in applying for assistance in the State in which they are currently residing.

States that have been authorized 1115 demonstration authority include Alabama, Arkansas, California, the District of Columbia, Florida, Georgia, Idaho, Indiana, Louisiana, Maryland, Mississippi, Nevada, Ohio, South Carolina, Tennessee, Texas and Puerto Rico.

CMS reviewed and approved waivers for states housing the vast majority of evacuees, and is now providing immediate, comprehensive relief for evacuees who have left their home state, regardless of whether they had previously been

determined eligible for Medicaid in their home state, or they are newly eligible for Medicaid due to loss of income and resources as a result of Hurricane Katrina.

This demonstration initiative permits Host States to offer Medicaid and SCHIP benefits to parents, pregnant women, children under age 19, individuals with disabilities, low-income Medicare recipients, and low-income individuals in need of long-term care within certain income parameters using a simplified eligibility chart or the eligibility levels from the affected States. As an evacuee, an individual is required to attest that he/she is displaced from certain geographic regions and to cooperate in demonstrating evacuee status.

Uncompensated Care Pools

CMS approved uncompensated care pools in several states. The uncompensated care pool allows States to reimburse providers that incur uncompensated care costs for medically necessary services and supplies for Katrina evacuees who do not have other coverage for such services and supplies through insurance, or other relief options available including Medicaid and SCHIP for a 5 month period effective from August 24, 2005, through January 21, 2006. The pool may also be used to provide reimbursement for benefits not covered under Medicaid and SCHIP in the states. These uncompensated care pools cannot be used to reimburse providers for uncompensated care costs beyond January 31, 2006 or for services provided to Medicaid and SCHIP eligibles in the host state.

The Role of 1135 Waivers

Section 1135 of the Social Security Act allows the Secretary of Health and Human Services to waive or modify certain Medicare, Medicaid, or SCHIP requirements to protect the public health and welfare in times of national crisis.

On August 27, 2005, President Bush made a disaster declaration in response to Hurricane Katrina. On Wednesday August 31, 2005 Secretary Leavitt notified the Congress that he was invoking his waiver authority, as a consequence of Hurricane Katrina, in order to protect the health and welfare of the public in areas impacted by this crisis. CMS is taking action consistent with this authority to ensure that the people in these areas receive all necessary health care services.

In his declaration, the Secretary specified that a public health emergency existed since August 24, 2005 in the State of Florida and since August 29, 2005 in the States of Alabama, Louisiana, and Mississippi. Declaring a public health emergency enabled the Secretary to authorize waivers to states in order to facilitate the provision of health care services. He began authorizing 1135 waivers on September 4, 2005, which became effective on September 6, 2005, but were effective retroactively to August 24, 2005 in Florida; August 29, 2005 in Alabama, Louisiana, and Mississippi; and September 2, 2005 in Texas. CMS approved waivers in other states that were directly affected by Hurricane Katrina or hosted evacuees, including Arkansas, Colorado, Georgia, North Carolina, Oklahoma, Tennessee, West Virginia, and Utah.

By issuing 1135 waivers to states affected by Hurricane Katrina, there was increased flexibility for providers and beneficiaries. The waivers flexed the normal eligibility and enrollment requirements used to apply for Federal benefits so that no one who has been a victim of the hurricane would be prevented from getting benefits. For instance, CMS recognized that many evacuees lost all identification and records, so the Agency gave states the flexibility to enroll people without requiring the usual documents such as tax returns or proof of residency. In addition, requirements were temporarily relaxed for

- certain conditions of participation, certification requirements, program participation or similar requirements, or pre-approval requirements for individual health care providers or types of health care providers, including as applicable, a hospital or other provider of services, a physician or other health care practitioner or professional, a health care facility, or a supplier of health care items or services;
- the requirement that physicians and other health care professionals hold licenses in the State in which they provide services, if they have a license from another State (and are not affirmatively barred from practice in that State or any State in the emergency area);
- sanctions under the Emergency Medical Treatment and Labor Act, or EMTALA, for the redirection of individuals to receive a medical screening examination or transfer;

- permitting Medicare Advantage enrollees to use out-of-network providers; and,
- sanctions and penalties arising from noncompliance with certain provisions of the HIPAA privacy regulations including the requirements to obtain a patient's agreement to speak with family members or friends or to honor a patient's request to opt out of the facility directory.

Through these efforts, evacuees are getting the care they need so they can get back on their feet. CMS is making sure that the health care community is reimbursed for providing that care. Further, the Agency is making sure that states hosting evacuees are covered for any substantial expenses that they incur.

Conclusion

Mr. Chairman and Members of the Subcommittee, Hurricane Katrina caused severe devastation. However, the network of compassion and caring demonstrated by federal, state, and local officials, as well as health care providers and others was a profound and powerful manifestation of the greatness of this country.

Providers rushed to care for those in need without even considering payments or program requirements. Providers, who were personally affected by the hurricane, as well as those in areas sheltering evacuees, have provided extensive medical services under the most challenging conditions. Our role is to

support their best efforts to care for seniors, people with a disability, children and families with limited means, and anyone else who needs care and has nowhere else to turn.

I want to assure you, Mr. Chairman and Members, that HHS is actively focused on working with the affected communities. HHS will continue its efforts to work with hospitals and other facilities and ensure they have adequate emergency plans in place should a disaster occur. And we are constantly reassessing the state of our preparedness for natural disasters, as well as terrorist attacks and disease outbreaks, in order to ensure the best outcomes for our future.

This concludes my testimony. I will be happy to answer any questions.